



## Complete Summary

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### GUIDELINE TITLE

Palliative care in lung cancer: ACCP evidence-based clinical practice guidelines.  
(2nd Edition)

### BIBLIOGRAPHIC SOURCE(S)

Kvale PA, Selecky PA, Prakash UB, American College of Chest Physicians. Palliative care in lung cancer: ACCP evidence-based clinical practice guidelines (2nd edition). Chest 2007 Sep;132(3 Suppl):368S-403S. [358 references] [PubMed](#)

### GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Kvale PA, Simoff M, Prakash UB. Lung cancer. Palliative care. Chest 2003 Jan;123(1 Suppl):284S-311S.

### \*\* REGULATORY ALERT \*\*

### FDA WARNING/REGULATORY ALERT

**Note from the National Guideline Clearinghouse:** This guideline references a drug(s) for which important revised regulatory information has been released.

- [May 2, 2007, Antidepressant drugs](#): Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.

### COMPLETE SUMMARY CONTENT

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## SCOPE

### **DISEASE/CONDITION(S)**

Symptoms and problems related to lung cancer

### **GUIDELINE CATEGORY**

Management  
Treatment

### **CLINICAL SPECIALTY**

Family Practice  
Oncology  
Pulmonary Medicine  
Radiation Oncology  
Thoracic Surgery

### **INTENDED USERS**

Advanced Practice Nurses  
Allied Health Personnel  
Health Care Providers  
Nurses  
Patients  
Physicians  
Psychologists/Non-physician Behavioral Health Clinicians  
Social Workers

### **GUIDELINE OBJECTIVE(S)**

To review the scientific evidence on symptoms and specific complications that are associated with lung cancer, and the methods available to palliate those symptoms and complications

### **TARGET POPULATION**

Patients with symptoms and problems related to lung cancer

### **INTERVENTIONS AND PRACTICES CONSIDERED**

#### **Treatment/Management**

1. Question patients about their pain regularly, using self-reports and simple rating scales
2. Individualize medications for each patient
3. Administer medications regularly and treat pain appropriately, questioning patients about their pain regularly

4. Acetaminophen or nonsteroidal anti-inflammatory drugs (NSAIDs) initially, opioids when necessary
5. Adjunctive medications such as tricyclic antidepressants, anticonvulsants, and neuroleptic agents
6. Administer medications by mouth (rectally or transdermally if necessary)
7. Treat constipation due to opioids prophylactically
8. Encourage patient to remain active
9. Complimentary methods of pain relief such as cutaneous stimulation, acupuncture, psychosocial therapy and pastoral care
10. Palliative radiation and chemotherapy
11. Refer patient to specialized pain clinic or palliative care consultant if pain is unresponsive
12. Evaluate patient complaining of dyspnea; use opioids or other pharmacologic and non-pharmacologic approaches
13. Evaluate patient with troublesome cough, use opioids to suppress
14. For patients with pain due to bone metastases:
  - Analgesics
  - Radiation therapy
  - Bisphosphonates with external radiation
  - Radiopharmaceuticals
  - Surgical fixation
15. For patients with symptomatic brain metastases:
  - Dexamethasone
  - Surgical resection of primary lung tumor (with non-small cell lung cancer [NSCLC])
  - Whole brain radiation therapy
  - Surgical resection of brain metastases
  - Stereotactic radiosurgery
  - Chemotherapy
16. For patients with spinal cord metastases:
  - Dexamethasone and radiotherapy
17. For patients with spinal cord compression:
  - Neurosurgical consultation
  - Corticosteroids
  - Radiation therapy
  - Surgery
18. For patients with hemoptysis:
  - Bronchoscopy
  - Endobronchial management
19. For patients with malignant pleural effusions:
  - Thoracentesis
  - Chest tube drainage
  - Pleurodesis
  - Fibrinolysis
  - Systemic chemotherapy
20. For patients with superior vena cava (SVC):
  - Chemotherapy
  - Stent insertion and/or radiation therapy
21. For patients with tracheoesophageal fistula, use stenting
22. Evaluate all patients for depression and treat appropriately

## **MAJOR OUTCOMES CONSIDERED**

- Pain relief
- Response rate
- Need for supplemental analgesia
- Quality of life
- Functional status

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)  
 Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

#### Overview

The American College of Chest Physicians (ACCP) chose the Duke University Center for Clinical Health Policy Research to perform formal systematic reviews of the current evidence in the five new non-small cell lung cancer (NSCLC) topic areas, as well as to provide a search for the existing guidelines, systematic reviews, and meta-analyses in all of the topics areas. In addition, the Agency for Healthcare Quality and Research (AHRQ) agreed to fund the BlueCross BlueShield Association Technology Evaluation Center to perform the formal systematic review of literature on small cell lung cancer (SCLC). The Health Outcomes Research Group of the Department of Epidemiology and Biostatistics at Memorial Sloan-Kettering Cancer Center conducted a full-scale review of the literature since the first set of guidelines in the area of screening for lung cancer to assist that particular writing group.

The formal systematic reviews of the five new topic areas were guided by the appropriate chapter editors and their writing committees, in concert with the Executive Committee of the panel.

The two EPC research teams conducted a variety of systematic computerized bibliographic database searches including the following: (1) a search for systematic reviews, guidelines, and meta-analyses published since the last ACCP lung cancer guideline (MEDLINE, The Cochrane Library, National Guidelines Clearinghouse); (2) targeted searches for reviews in each of five selected treatment sections (solitary pulmonary nodules, stage I and II, stage IIIA, stage IIIB, stage IV); these searches, run in OVID version of MEDLINE, were performed in July and August 2005 and were limited to publication years since 1995, English language, and human subjects; and (3) searches related to SCLC are described in the evidence chapter on SCLC. Search terms included the medical subject heading terms lung neoplasms (exploded) and bronchial neoplasms for the lung cancer concept. Each topic search utilized key words specific to the key questions of interest (complete search strategies are available on request from the authors).

#### Strategy Specific for Palliative Care in Lung Cancer

The key words for various palliative care topics, as listed in above-mentioned "Key words" section, were searched using Ovid MEDLINE and PubMed from 1966 through March 1, 2006. Randomized controlled trials (RCTs) were especially sought for all such topics; where this type of study was available, it is clearly identified as such in the appropriate section of this chapter. For many of the topics, evidence is of substantially less quality, and it typically consists of case series of varying size. This has led to recommendations that are based on publications describing clinical experience with varying sizes of patient population. The sections that discuss approaches to treatment of airway obstruction and hemoptysis, as well as palliation of malignant pleural effusion are examples where the evidence-based literature pertaining to palliative therapy is limited.

## **NUMBER OF SOURCE DOCUMENTS**

Not stated

## **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Expert Consensus

Weighting According to a Rating Scheme (Scheme Given)

## **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

**High** Randomized controlled trials (RCTs) without important limitations or overwhelming evidence from observational studies\*

**Moderate** RCTs with important limitations (inconsistent results, methodologic flaws, indirect, or imprecise) or exceptionally strong evidence from observational studies\*

**Low or very low** Observational studies or case series

\*Although the determination of magnitude of the effect based on observational studies is often a matter of judgment, the guideline developers offer the following suggested rule to assist this decision: a large effect would be a relative risk  $>2$  (risk ratio  $< 0.5$ ) [which would justify moving from weak to moderate], and a very large effect is a relative risk  $> 5$  (risk ratio  $< 0.2$ ) [which would justify moving from weak to strong]. There is some theoretical justification in the statistical literature for these thresholds (the magnitude of effect that is unlikely or very unlikely to be due to residual confounding after adjusted analysis). However, once the decision is made, authors should be explicit in justifying their decisions.

## **METHODS USED TO ANALYZE THE EVIDENCE**

Review of Published Meta-Analyses

Systematic Review

## **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Quality of evidence is scored in three categories with high-quality evidence obtained from randomized controlled trials (RCTs) without important methodologic limitations based on the study design, the consistency of the results, and the

directness of the evidence. In extraordinary circumstances, significant and consistent evidence from observational studies could also be ranked as high quality. RCTs with important methodologic limitations or flaws, inconsistent results, or indirect or imprecise results would be scored as medium quality, as well as exceptionally strong evidence from observational studies. Other observational studies or case-series data would fall into the low quality of evidence category. It is the interface of the quality of the evidence and the balance of benefits to harms or burdens that determines the strength of the recommendation, with a 1A recommendation being the strongest and 2C the weakest.

## **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus  
Informal Consensus

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Writing committees studied the evidence and summary tables or reviewed the literature for their assigned topics, developing their arguments for the recommendations and suggested grading of those recommendations that were put forth for early drafts. The Executive Committee of the panel, composed of the Chair, Vice-Chair, methodologist, and both project managers, reviewed drafts of each chapter of the manuscript during the writing process. Sections that were determined to be potentially overlapping were shared among the appropriate chapter editors, and conference calls were organized to coordinate the placement of these sections and to confirm that there would be no conflicting information or recommendations.

A conference of the panel was convened in July 2006, prior to which time all panelists, including representatives from the invited organizations, were requested to review the complete manuscript and identify recommendations for which the proposal, wording, or grading were determined to be controversial or could be interpreted as controversial by others, incorrectly evolved from the evidence, disagreement existed with regard to the proposal or the grading, or required full panel discussion and further review for any reason. When the panelists who were present were not in unanimous agreement with the proposed recommendations or the grading of the recommendations, informal group consensus techniques were employed. After the meeting, a series of conference calls were convened to finish the discussions and finalize the recommendations. There were a few chapters for which there was insufficient time for full dialogue during the meeting; in the interest of ensuring that the recommendations followed the evidence, the conference calls were necessary. This process ensured the "buy-in" of the panelists and was deemed to be a worthwhile effort.

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

### **Grade of Recommendations Scale**

Grade	Recommendation
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Grade	Recommendation
1A	Strong
1B	Strong
1C	Strong
2A	Weak
2B	Weak
2C	Weak

### Relationship of Strength of the Supporting Evidence to the Balance of Benefits to Risks and Burdens

Balance of Benefits to Risks and Burdens				
Quality of Evidence	Benefits Outweigh Risks/Burdens	Risks/Burdens Outweigh Benefits	Evenly Balanced	Uncertain
High	1A	1A	2A	
Moderate	1B	1B	2B	
Low or very low	1C	1C	2C	2C

### COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

### METHOD OF GUIDELINE VALIDATION

Peer Review

### DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Following final chapter revisions and incorporation of these ultimate recommendations and grading, a concluding review was conducted by the guideline panel Executive Committee. The guidelines were then submitted for review and approval to the American College of Chest Physicians Health and Science Policy Committee (ACCP HSP) Committee, as well as the Thoracic Oncology Network of the college.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

Definitions for the strength of evidence and recommendation grades (1A-2C) follow the recommendations.

1. All lung cancer patients and their families must be reassured that pain can be relieved safely and effectively. All patients should be questioned regularly

- about their pain, using the patient's self-report of pain and a simple rating scale as the primary source of assessment. **Grade of recommendation, 1A**
2. For all patients, individualize medications that are used to control pain. Administer medications regularly and treat pain appropriately. Document the effectiveness of pain management at regular intervals during treatment. **Grade of recommendation, 1A**
  3. For all patients with mild-to-moderate pain, manage the pain initially with acetaminophen or a nonsteroidal anti-inflammatory drug (NSAID), assuming there are no contraindications to their use. Use opioids when pain is more severe or when it increases. **Grade of recommendation, 1B**
  4. For any patient, if it is anticipated that there will be a continuous need for opioid medication, meperidine is not recommended. It has a short duration of action, and its metabolite normeperidine is toxic and can cause CNS stimulation resulting in dysphoria, agitation, and seizures. **Grade of recommendation, 1B**
  5. For patients whose pain is not controlled by pure analgesic medications, adjunctive medications such as tricyclic antidepressants, anticonvulsants, and neuroleptic agents will often augment the effects of pure analgesic medications. **Grade of recommendation, 1C**
  6. For all patients, administer medications by mouth because of convenience and cost-effectiveness. In patients with lung cancer who cannot take pain medications by mouth, rectal and transdermal administration are recommended. Administration of analgesics by the intramuscular (IM) route is not recommended because of pain, inconvenience, and unreliable absorption. **Grade of recommendation, 1C**
  7. For all patients receiving opioids, because constipation is common, anticipate it, treat it prophylactically, and constantly monitor it. **Grade of recommendation, 1B**
  8. Encourage all patients to remain active and to care for themselves whenever possible. Avoid prolonged immobilization whenever possible. **Grade of recommendation, 1B**
  9. In patients who have pain associated with muscle tension and spasm, it is recommended that complimentary methods for pain relief such as cutaneous stimulation techniques (heat and cold applications), acupuncture, psychosocial methods of care, and pastoral care be incorporated into the pain-management plan, but not as a substitute for analgesics. **Grade of recommendation, 1C**
  10. For patients with advanced lung cancer, provide palliative radiation therapy to control pain. Palliative chemotherapy to decrease pain and other symptoms is recommended even though the increase in survival may be only modest. **Grade of recommendation, 1B**
  11. In patients with lung cancer who have pain unresponsive to standard methods of pain control, referral to a specialized pain clinic or palliative care consultant is recommended. **Grade of recommendation, 1C**
  12. For all lung cancer patients who complain of dyspnea, it is recommended that they be evaluated for potentially correctable causes, such as localized obstruction of a major airway, a large pleural effusion, pulmonary emboli, or an exacerbation of coexisting COPD or congestive heart failure. If one of these problems is identified, treatment with appropriate methods is recommended. **Grade of recommendation, 1C**
  13. For all lung cancer patients whose dyspnea does not have a treatable cause, opioids are recommended. Also recommended are other pharmacologic

- approaches such as oxygen, bronchodilators, and corticosteroids. **Grade of recommendation, 1C**
14. For all lung cancer patients with dyspnea, it is recommended that nonpharmacologic and noninterventional treatments be considered, such as patient and family education, breathing control, activity pacing, relaxation techniques, fans, and psychosocial support. **Grade of recommendation, 2C**
  15. For all lung cancer patients who have troublesome cough, it is recommended that they be evaluated for treatable causes. **Grade of recommendation, 1B**
  16. For all lung cancer patients who have troublesome cough without a treatable cause, it is recommended that opioids be used to suppress the cough. **Grade of recommendation, 1B**
  17. For patients with lung cancer who have pain due to bone metastases, external radiation therapy is recommended for pain relief. A single fraction of 8 Gy is as effective as higher fractionated doses of external radiation therapy for immediate relief of pain. **Grade of recommendation, 1A**
  18. For patients with lung cancer who have pain due to bone metastases, higher fractionated doses of radiation therapy provide a longer duration of pain relief, less frequent need for retreatment, and fewer skeletal-related events than does a single fraction. **Grade of recommendation, 1A**
  19. For patients with lung cancer who have painful bone metastases bisphosphonates are recommended together with external radiation therapy for pain relief. **Grade of recommendation, 1A**
  20. For patients with lung cancer who have painful bone metastases refractory to analgesics, radiation and bisphosphonates, radiopharmaceuticals are recommended for pain relief. **Grade of recommendation, 1B**
  21. In patients with lung cancer who have painful bone metastases to long and/or weight-bearing bones and a solitary well-defined lytic lesion circumferentially involving > 50% of the cortex and an expected survival > 4 weeks with satisfactory health status, surgical fixation is recommended to minimize the potential for a fracture. Intramedullary nailing is the preferred approach, especially for the femur or the humerus. **Grade of recommendation, 1C**
  22. In patients with lung cancer who have symptomatic brain metastases, dexamethasone, 16 mg/d, is recommended during the course of definitive therapy with a rapid taper and discontinuation within 6 weeks of completion of definitive therapy (either surgery or radiation therapy). **Grade of recommendation, 1B**
  23. Patients with non-small cell lung cancer (NSCLC) and an isolated solitary brain metastasis should be considered for a curative resection of the lung primary tumor as long as a careful search for other distant metastases or mediastinal lymph nodes has been carried out and is negative. **Grade of recommendation, 1C**
  24. In patients with no other sites of metastases and a synchronous resectable N0,1 primary NSCLC, resection or radiosurgical ablation of an isolated brain metastasis should be undertaken (as well as resection of the primary tumor). Resection of the isolated solitary brain metastases should be followed by whole-brain radiation therapy (WBRT). **Grade of recommendation, 1B**
  25. For patients with lung cancer who have new onset of back pain, sagittal T1-weighted MRI of the entire spine is recommended for diagnostic purposes. Other diagnostic studies such as plain radiographs, bone scans, or computed tomography (CT) myelograms are not recommended. **Grade of recommendation, 1C**

26. For patients with lung cancer and epidural spinal cord metastases who are not paretic and ambulatory, prompt treatment with high-dose dexamethasone and radiotherapy is recommended. **Grade of recommendation, 1B**
27. When there is symptomatic radiographically confirmed compression of the spinal cord, neurosurgical consultation must be sought and, if appropriate, surgery should be performed immediately and followed by radiation for patients with metastatic epidural spinal cord compression and generally good performance status. **Grade of recommendation, 1A**
28. For all lung cancer patients with large-volume hemoptysis, bronchoscopy is recommended to identify the source of bleeding, followed by endobronchial management options such as argon plasma coagulation (APC), neodymium-doped yttrium aluminium garnet (Nd-YAG) laser, and electrocautery. **Grade of recommendation, 1C**
29. In lung cancer patients with symptomatic malignant pleural effusions, thoracentesis is recommended as the first drainage procedure for symptom relief. **Grade of recommendation, 1C**
30. In lung cancer patients with symptomatic pleural effusions that recur after thoracentesis, chest tube drainage and pleurodesis are recommended. **Grade of recommendation, 1B**
31. In patients with superior vena cava (SVC) obstruction from suspected lung cancer, definitive diagnosis by histologic or cytologic methods is recommended before treatment is started. **Grade of recommendation, 1C**
32. In patients with symptomatic SVC obstruction due to SCLC, chemotherapy is recommended. **Grade of recommendation, 1C**
33. In patients with symptomatic SVC obstruction due to NSCLC, stent insertion and/or radiation therapy are recommended. Stents are also recommended for small cell lung cancer (SCLC) or NSCLC symptomatic patients with SVC obstruction who fail to respond to chemotherapy or radiation therapy. **Grade of recommendation, 1C**
34. For patients with a malignant tracheoesophageal fistula (TEF) or bronchoesophageal fistula, stenting of esophagus, airway, or both should be considered for symptomatic relief. Attempts at curative resection or esophageal bypass of the involved airway and/or the esophagus are not recommended. **Grade of recommendation, 1C**
35. It is recommended that all patients with lung cancer be evaluated for the presence of depression and, if present, treated appropriately. **Grade of recommendation, 1C**

### **Definitions:**

#### **Quality of Evidence Scale**

**High** - Randomized controlled trials (RCTs) without important limitations or overwhelming evidence from observational studies\*

**Moderate** - RCTs with important limitations (inconsistent results, methodologic flaws, indirect, or imprecise) or exceptionally strong evidence from observational studies\*

**Low or very low** - Observational studies or case series

\*Although the determination of magnitude of the effect based on observational studies is often a matter of judgment, the guideline developers offer the following suggested rule to assist this decision: a large effect would be a relative risk > 2 (risk ratio < 0.5) [which would justify moving from weak to moderate], and a very large effect is a relative risk > 5 (risk ratio < 0.2) [which would justify moving from weak to strong]. There is some theoretical justification in the statistical literature for these thresholds (the magnitude of effect that is unlikely or very unlikely to be due to residual confounding after adjusted analysis). However, once the decision is made, authors should be explicit in justifying their decisions.

## Grade of Recommendations Scale

Grade	Recommendation
1A	Strong
1B	Strong
1C	Strong
2A	Weak
2B	Weak
2C	Weak

## Relationship of Strength of the Supporting Evidence to the Balance of Benefits to Risks and Burdens

Balance of Benefits to Risks and Burdens				
Quality of Evidence	Benefits Outweigh Risks/Burdens	Risks/Burdens Outweigh Benefits	Evenly Balanced	Uncertain
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Moderate	1B	1B	2B	
Low or very low	1C	1C	2C	2C

## CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

Appropriate palliative care for patients with lung cancer

## POTENTIAL HARMS

- Constipation is a side effect of *opioid* medications. *Opioids* may also cause respiratory depression/hypoventilation as well as somnolence.
- Significant side effects occur in those who receive high-dose *dexamethasone*. Side effects include cushingoid facies, peripheral edema, and steroid-induced myopathy.
- Side effects of *whole brain radiotherapy* may include measurable deterioration of neuropsychological function.
- Continuous intravenous infusion of *morphine* has the possibility of causing severe hypoventilation and hypercarbic respiratory failure and death. The major side effect of *morphine* is sedation.

### Risks Associated with Bronchoscopic Methods

See Table 1 of the original guideline document for palliative bronchoscopic therapies and associated complications.

## CONTRAINDICATIONS

### CONTRAINDICATIONS

- Contraindications to surgical treatment of metastatic disease to long bones include a survival expectancy <4 weeks, and a poor general condition that is an obstacle to a safe operation.
- Larger lesions, particularly those in the posterior fossa, are a relative contraindication for radiosurgery.
- A nonsteroidal anti-inflammatory drug (NSAID) or acetaminophen should be used unless there is a contraindication (e.g., increased risk of cardiovascular events and GI bleeding with NSAID medications).

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

The publication of the *Diagnosis and Management of Lung Cancer: ACCP Evidence-Based Clinical Practice Guidelines; Second Edition* in *CHEST* is the first of two dissemination vehicles. The circulation of the journal is 23,000 subscribers and libraries, including six translations and distribution to 107 countries. All subscribers received a copy of this full-text guideline. The American College of Chest Physicians (ACCP) Clinical Resource on Lung Cancer is composed of a printed publication and an accompanying CD-ROM, containing a quick reference guide for physicians and other health-care providers, patient-targeted educational materials, and a set of slides for use in educational or clinical contexts. In addition, the recommendations and grading are personal digital assistant downloadable from the clinical resource. This product is available for purchase from the ACCP. The patient education materials are accessible free of charge on [www.chestnet.org](http://www.chestnet.org).

The implementation and translation of evidence-based clinical practice guidelines facilitates knowledge uptake, critical for practice change, and should ultimately lead to better patient-focused care. The HSP Subcommittee on Implementation has proposed to collaborate with the Governors, Thoracic Oncology Network, and other groups within the ACCP to disseminate and implement the guidelines in their local communities. Residency and specialty training programs are encouraged to use the guidelines in journal clubs and grand rounds. Other organizations that were invited to send representatives to the final conference and review the proposed drafts were also requested to endorse the guidelines and market them to their membership through their own communication channels.

## **IMPLEMENTATION TOOLS**

Patient Resources  
Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## **INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES**

### **IOM CARE NEED**

End of Life Care  
Living with Illness

### **IOM DOMAIN**

Effectiveness  
Patient-centeredness

## **IDENTIFYING INFORMATION AND AVAILABILITY**

### **BIBLIOGRAPHIC SOURCE(S)**

Kvale PA, Selecky PA, Prakash UB, American College of Chest Physicians. Palliative care in lung cancer: ACCP evidence-based clinical practice guidelines (2nd edition). Chest 2007 Sep;132(3 Suppl):368S-403S. [358 references] [PubMed](#)

### **ADAPTATION**

The comments in the section on pain control were adapted from:

- Jacos A, Carr DB, Payne R. Management of cancer pain. Rockville, MD: Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, Public Health Service, 1994.
- Goudas L, Carr DB, Bloch R. Management of cancer pain. Rockville, MD: Agency for Healthcare Research and Quality, 2001.

- Miaskowski C, Cleary J, Burney R, et al. Guideline for the management of cancer pain in adults and children. Glenview, IL: American Pain Society, 2005.

## **DATE RELEASED**

2003 Jan (revised 2007 Sep)

## **GUIDELINE DEVELOPER(S)**

American College of Chest Physicians - Medical Specialty Society

## **SOURCE(S) OF FUNDING**

American College of Chest Physicians

## **GUIDELINE COMMITTEE**

American College of Chest Physicians (ACCP) Expert Panel on Lung Cancer Guidelines

## **COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

*Primary Authors:* Paul A. Kvale, MD, FCCP; Paul A. Selecky, MD, FCCP; Udaya B. S. Prakash, MD, FCCP

## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Funding for both the evidence review and guideline development was supported by educational grants from AstraZeneca LP, Bristol-Myers Squibb Company, Eli Lilly and Company, Genentech, and Sanofi-Aventis. Representatives from these companies were neither granted the right of review, nor were they allowed participation in any portion of the guideline development process. This precluded participation in either conference calls or conferences. No panel members or ACCP reviewers were paid any honoraria for their participation in the development and review of these guidelines.

The ACCP approach to the issue of potential or perceived conflicts of interest established clear firewalls to ensure that the guideline development process was not influenced by industry sources. This policy is published on the ACCP Web site at [www.chestnet.org](http://www.chestnet.org). All conflicts of interest within the preceding 5 years were required to be disclosed by all panelists, including those who did not have writing responsibilities, at all face-to-face meetings, the final conference, and prior to submission for publication. The most recent of these conflict of interests are documented in this guideline Supplement. Furthermore, the panel was instructed in this matter, verbally and in writing, prior to the deliberations of the final conference. Any disclosed memberships on speaker's bureaus, consultant fees, grants and other research monies, and any fiduciary responsibilities to industry were provided to the full panel in writing at the beginning of the conference and at submission for publication.

## **ENDORSER(S)**

American Association for Bronchology - Disease Specific Society  
American Association for Thoracic Surgery - Medical Specialty Society  
American College of Surgeons - Medical Specialty Society  
American Society for Therapeutic Radiology and Oncology  
Asian Pacific Society of Respiriology - Disease Specific Society  
Oncology Nursing Society - Professional Association  
Society of Thoracic Surgeons - Medical Specialty Society  
World Association of Bronchology - Disease Specific Society

## **GUIDELINE STATUS**

This is the current release of the guideline.

This guideline updates a previous version: Kvale PA, Simoff M, Prakash UB. Lung cancer. Palliative care. Chest 2003 Jan;123(1 Suppl):284S-311S.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available to subscribers of [Chest - The Cardiopulmonary and Critical Care Journal](#).

Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following are available:

Executive Summary:

- Alberts MW. Diagnosis and management of lung cancer executive summary. Chest 2007 Sep;132(3 Suppl):1S-19.

Background Articles:

- Alberts WM. Introduction: diagnosis and management of lung cancer. Chest 2007 Sep;132(3 Suppl):20S-22.
- McCrory DC, Lewis SZ, Heitzer J, Colice GL, Alberts WM. Methodology for lung cancer evidence review and guideline development. Chest 2007 Sep;132(3 Suppl):23S-28.
- Alberg AJ, Ford JG, Samet JM. Epidemiology of lung cancer. Chest 2007 Sep;132(3 Suppl):29S-55.

Electronic copies: Available to subscribers of [Chest - The Cardiopulmonary and Critical Care Journal](#).

Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

The following is also available:

- ACCP clinical resources: Diagnosis and management of lung cancer: ACCP evidence-based clinical practice guidelines (2nd edition).

Available from the [American College of Chest Physicians Web site](#).

## **PATIENT RESOURCES**

The following are available:

- Lung cancer guides: lung cancer...am I at risk? Patient education guide. Northbrook (IL): American College of Chest Physicians, 2004. 12 p.
- Lung cancer guides: What if I have a spot on my lung? Do I have cancer? Patient education guide. Northbrook (IL): American College of Chest Physicians, 2004. 16 p.
- Lung cancer guides: living with lung cancer. Patient education guide. Northbrook (IL): American College of Chest Physicians, 2004. 12 p.
- Lung cancer guides: advanced lung cancer: issues to consider. Patient education guide. Northbrook (IL): American College of Chest Physicians, 2004. 12 p.

Electronic copies: Available in Portable Document Format (PDF) from the [American College of Chest Physicians \(ACCP\) Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## **NGC STATUS**

This NGC summary was completed by ECRI on September 3, 2003. The information was verified by the guideline developer on October 1, 2003. This summary was updated on May 3, 2005 following the withdrawal of Bextra (valdecoxib) from the market and the release of heightened warnings for Celebrex (celecoxib) and other nonselective nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI on June 16, 2005, following the U.S. Food and Drug Administration advisory on COX-2 selective and non-selective non-steroidal anti-inflammatory drugs (NSAIDs). This NGC summary was updated by ECRI Institute on November 29, 2007. The updated information was verified by the guideline developer on December 21, 2007.

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